

1434
CERTIFICATE OF DEATH

01411

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Geo. G. Meade, Md</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Odenton, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>US Army Hospital, Ft Geo. G. Meade, Md</u>				d. STREET ADDRESS <u>343-A Patuxent Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Alexander</u> Last <u>Abell</u>				4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 12 1938</u>	
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>/////</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Rose (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>//////////</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mrs. Virginia Widener, Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head Injuries</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Automobile Accident</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Head Trauma occurred during Auto Accident</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>Feb 15</u> 19 <u>59</u> p. m. <u> </u> <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Reece Road</u>	
20f. (City or town) <u>Ft Meade</u>				20g. (County) <u>Anne Arundel</u>		20h. (State) <u>Md</u>	
21. I certify that I attended the deceased from <u>15 February, 1959</u> , to <u>15 February 1959</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>0405</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James H Glenn</u>				DATE SIGNED <u>Feb 15, 1959</u>			
PHYSICIAN'S NAME (Type) <u>JAMES H GLENN</u>				ADDRESS (Street, city or town, state) <u>USAH Ft Geo G Meade, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Glen Burnie, Maryland</u>				22e. (State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard L. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Prange</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

I, the undersigned, certify that I Have picked up the remains of Robert A Abell on 15 Feb 1959 from the USAH, Ft George G Meade, Md. per Dr Faubert, county corner.

Richard V. Slaughter

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1435

CERTIFICATE OF DEATH

01412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ad. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Ad. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waterbury Md</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Catherine J Alton</u> First <u>Alton</u> Middle Last		4. DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-1890</u> 68 yrs.
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Hall</u>		14. MOTHER'S MAIDEN NAME <u>Martha Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hazel Alton</u> Address <u>Waterbury Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis of the heart and coronary arteries</u> DUE TO (c) <u>Basal disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 28</u> to <u>2/4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/3</u> , 19 <u>59</u> , and that death occurred at <u>9:05 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. R. Richardson</u>		ADDRESS (Street, city or town, state) DATE <u>110- Day 8</u> <u>Feb 6 1959</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-8-1959</u>	<u>John Wesley</u>	<u>Waterbury Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese #108 Wash St Clarks Md</u>		24a. REC'D BY REGISTRAR <u>FEB 6 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [unclear]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK - BUREAU OF HEALTH

NEW YORK

DECEASED

NAME

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CERTIFICATE OF DEATH

1409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AA General</u>				d. STREET ADDRESS <u>1114 Chester Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Henry</u> Last <u>Atwell</u>				4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 19-1874</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER Ret. and Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AA Co Md</u>		11. BIRTHPLACE (State or foreign country) <u>N. S. A</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Clyde F. Atwell</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>18 FEB</u> , 19 <u>59</u> , to <u>22 FEB</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>22 FEB</u> , 19 <u>59</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward L. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>41 Southgate AVE</u> DATE SIGNED <u>2/23/59</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK MD, ANNAPOLIS, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Edwards Chapel Cemt</u>		22d. LOCATION (City, town, or county) (State) <u>Parole AA Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gulm M. Sayles Sons Annapolis Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE 25 '59</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

01414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>53 Collage Ave</u>		d. STREET ADDRESS <u>153 Collage Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bessie Bruce Baker</u>		4. DATE OF DEATH Month Day Year <u>2-10-1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26-1870</u> 88 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millinery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>	9. AGE (In years and birthday) <u>88</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred B. Baker</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Bruen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Charles F Lee</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1, 1957</u> , to <u>Feb 10, 1959</u> , that I last saw the deceased alive on <u>Feb 10, 1959</u> , and that death occurred at <u>1:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD.</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		DATE SIGNED <u>Feb 10, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm M. Taylor Sins</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>Feb 12 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. JONES</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-15-1915</u></p>		<p>4. Place of birth: <u>NEW YORK, N.Y.</u></p>	
<p>5. Date of death: <u>10-25-1965</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>10-26-1965</u></p>		<p>12. Office of registration: <u>BALTIMORE</u></p>	

1436

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pumphrey</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Baltimore e 25 (Pumphrey)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>315 Key Ave</u>				d. STREET ADDRESS <u>1315 Key Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>Beverly</u> Last <u>Beverly</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12 Nov 1912</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u> Hours <u>46</u> Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Beverly</u>				14. MOTHER'S MAIDEN NAME <u>Anne Riddle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Armita Beverly</u>		17. INFORMANT <u>315 Key Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) <u>thnk</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month <u>Feb</u> Day <u>11</u> Year <u>1959</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9 Feb</u> , 19 <u>59</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Renold B. Lightston Jr.</u>				ADDRESS (Street, city or town, state) <u>501 Cherry Hill Road</u> DATE SIGNED <u>Baltimore - 25 Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Renold B. Lightston Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/14/1959</u>		<u>St. Paul's Cem.</u>		<u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Kate R. Williams</u>				24a. REC'D BY REGISTRAR <u>Schneider St.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01416

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>life time</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Earleigh Heights Rd.</u>			d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Edward Bey</u>			4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>19 59</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/58</u>	9. AGE (in years last birthday) <u>20</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Earleigh Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>John Bey</u>		
14. MOTHER'S MAIDEN NAME <u>Julia Graham</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Mrs. Julia Bey (mother)</u> Address <u></u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Charred above recognition</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was in bed on second floor when home caught on fire.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>2:40</u> a. m. <u>2/12/59</u> 19 p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Severna Park, A.A.</u>	(County) <u></u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/12/59</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-15-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>First Baptist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Earleigh Hghts., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson, Annapolis, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>FEB 16 '59</u>		
ADDRESS <u></u>			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinsler</u>		

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1438

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>Life time</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Earleigh Heights Rd.</u>			e. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Juliat Bey</u>			4. DATE OF DEATH February 12 19 59		
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/54</u>	9. AGE (In years last birthday) <u>4</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Earleigh Heights, Md.</u>	
13. FATHER'S NAME <u>John Bey</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Julia Bey (mother)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Charred above recognition</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was in bed on second floor when home caught on fire.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>2:40</u> <u>2/12/59</u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Severna Park, Md.</u>	(County) <u>A.A.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/12/59</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-15-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>First Baptist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Earleigh Hghts., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Johnson, Annapolis, Md.</u>			24a. REC'D BY REGISTRAR <u>FEB 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlino S. Hume</u>

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. BROOKS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH 1888	
5. PLACE OF BIRTH NEW YORK		6. OCCUPATION None	
7. MARITAL STATUS Married		8. EDUCATION High School	
9. PRESENT RESIDENCE 1234 Main St., Baltimore, Md.		10. DATE OF DEATH 1955	
11. CAUSE OF DEATH Myocardial Infarction		12. MANNER OF DEATH Natural	
13. SIGNATURE OF EXAMINER [Signature]		14. SIGNATURE OF WITNESSES [Signatures]	
15. SIGNATURE OF CORONER [Signature]		16. SIGNATURE OF JURY [Signatures]	

JOHN J. BROOKS
65
NEW YORK
None
Married
High School
1234 Main St., Baltimore, Md.
1955
Myocardial Infarction
Natural
[Signature]
[Signatures]
[Signature]
[Signatures]

Item 1 Film 6241 5-1-59 et

1439

02594

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROUNSVILLE</u> c. LENGTH OF STAY IN 1b <u>92 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROUNSVILLE STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE CITY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3Y01-4</u> d. STREET ADDRESS <u>1519-MULLIKENS CT</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>BLAND</u> Last <u>BLAND</u>				4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>1959</u>													
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 11, 1886</u>		9. AGE (In years last birthday) <u>72</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MOLDER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FOUNDRY</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>WILLIAM BLAND</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET BROADWAY</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>ADA BLAND</u>		Address <u>SAME</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - hypostatic</u> DUE TO (b) <u>Senility</u> DUE TO (c) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>1-15</u> , 19 <u>57</u> , to <u>2-27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>27 February</u> , 19 <u>59</u> , and that death occurred at <u>8:40</u> P.M., from the causes and on the date stated above.																	
ACTUAL SIGNATURE <u>James M. Hays Mapp</u>				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u>		DATE SIGNED											
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u>				Crownsville		Ad.											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-2-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MOUNT AUBURN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE</u> <u>MD</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. O. Watson</u>				ADDRESS <u>1000</u> <u>Brentwood</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Kneiss</u>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE

SEX
AGE

1888

1888

1888



1888

1888

1888

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1888

1888

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN 1b Baltimore 26		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 26 (Pasadena)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 432 Carvel Beach Road				d. STREET ADDRESS 432 Carvel Beach Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORMA Middle FAY Last BOIES				4. DATE OF DEATH Month February Day 13 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 30 yrs.		9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1745		10b. KIND OF BUSINESS OR INDUSTRY Heck Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Willard Boies			14. MOTHER'S MAIDEN NAME Barbara Jewell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family - Jane Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute barbiturate intoxication 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingestion of barbiturate					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 2/13 19 59		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles S. Petty, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) B.		22b. DATE THEREOF 2/17/59		22c. NAME OF CEMETERY OR CREMATORY Int. Olm.		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE McClary Funeral Home ADDRESS 130 E. Fort Ave.				24a. REC'D BY REGISTRAR DATE FEB 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle E Last BOOKER		4. DATE OF DEATH Month 2 Day 28 Year 1959	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-10-99
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen Maid		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Reed		14. MOTHER'S MAIDEN NAME Mary Banks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO hemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO chronic brain syndrome associated cerebral (c) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH few days since 1953
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/16/59 , 19____, to 2/28/59 , 19____, that I last saw the deceased alive on 2/24/59 , 19____, and that death occurred at 1045 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. BENEDICT		ADDRESS (Street, city or town, state) Crownsville State Hospital	
PHYSICIAN'S NAME (Type) L. BENEDICT		DATE SIGNED Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/5/59	22c. NAME OF CEMETERY OR CREMATORY Belhel Cem.	22d. LOCATION (City, town, or county) (State) Mechanic, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Randolph Gollick		ADDRESS 1412 E. Preston St.	
24a. REC'D BY REGISTRAR MAR 8 1959		24b. REGISTRAR'S SIGNATURE Charles S. Kane	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1411
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6 Martin St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Olivia</i> Middle <i>Bright</i> Last <i>Bright</i>		4. DATE OF DEATH Month <i>2-</i> Day <i>18</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 10-1888</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Joseph B. Ninton</i>	
14. MOTHER'S MAIDEN NAME <i>Martha Brangell</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Edward G. Russell (2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Thrombosis</i> DUE TO <i>Coronary Thrombosis</i> (c) <i>Hyperthrombosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hrs</i> <i>3 wks</i> <i>4 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 25, 1959</i> to <i>Feb 18, 1959</i> , that I last saw the deceased alive on <i>2-18, 1959</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Oliver Purvis</i> M.D.		ADDRESS (Street, city or town, state) <i>2-19-59</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>J. Oliver Purvis</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-20-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor-Sims</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 24 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kross</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See 216.511

NAME OF DECEASED [Handwritten: <i>John Doe</i>]		SEX [Handwritten: <i>Male</i>]		AGE [Handwritten: <i>45</i>]		DATE OF BIRTH [Handwritten: <i>Jan 15 1900</i>]		PLACE OF BIRTH [Handwritten: <i>Baltimore, Md.</i>]	
OCCUPATION [Handwritten: <i>Teacher</i>]		CAUSE OF DEATH [Handwritten: <i>Heart Disease</i>]		MANNER OF DEATH [Handwritten: <i>Natural</i>]		PLACE OF DEATH [Handwritten: <i>Home</i>]		DATE OF DEATH [Handwritten: <i>Dec 10 1945</i>]	
SIGNATURE OF PHYSICIAN [Handwritten: <i>J. Oliver Lewis</i>]		SIGNATURE OF REGISTRAR [Handwritten: <i>John Doe</i>]		SIGNATURE OF WITNESS [Handwritten: <i>John Doe</i>]		SIGNATURE OF WITNESS [Handwritten: <i>John Doe</i>]		SIGNATURE OF WITNESS [Handwritten: <i>John Doe</i>]	
CERTIFICATE OF DEATH [Handwritten: <i>John Doe</i>]		CERTIFICATE OF DEATH [Handwritten: <i>John Doe</i>]		CERTIFICATE OF DEATH [Handwritten: <i>John Doe</i>]		CERTIFICATE OF DEATH [Handwritten: <i>John Doe</i>]		CERTIFICATE OF DEATH [Handwritten: <i>John Doe</i>]	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the city or county in which the death occurred.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01421

1442

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>404 Myrtle Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>BROWN</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/23/23</u>
9. AGE (In years last birthday) <u>35 (2)</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>Jack BROWN</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1945</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Records of Crownsville State Hospital</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute Myocardial Infarct.</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease.</u>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Alcoholism.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Golden</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Golden</u> , 19 <u>58</u> , to <u>Febuary</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>13 Febuary</u> , 19 <u>59</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russell Henry Mapp</u>		DATE SIGNED <u>Crownsville State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp</u>		M.D. <u>Crownsville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-18-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL/DIRECTOR'S SIGNATURE <u>Adolphus Halstead</u>		24a. REC'D BY REGISTRAR <u>16 '59</u>	
ADDRESS <u>298 Hill Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>	

1941

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

1941

BUREAU OF VITAL RECORDS

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
100 NORTH ST. - BOSTON, MASS. 02109
TELEPHONE 5-2200
FAX 5-2200

CERTIFICATE OF DEATH

Reg. Dist. No.

1412

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jerry Middle Lynn Last Brown		4. DATE OF DEATH Month February Day 26 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 25, 1959
9. AGE (In years last birthday) 12		10. IF UNDER 1 YEAR Months 12 Days 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Clarence Gilmer Brown		14. MOTHER'S MAIDEN NAME Carolyn Jeannette Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Mother	
17. ADDRESS Rt. 1, Box 406A		18. ADDRESS Odenton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) diffuse pulmonary atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) prematurity DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 hrs 12 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Manth, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 25 Feb , 19 59 , to 26 Feb , 19 59 , that I last saw the deceased alive on 25 Feb , 19 59 , and that death occurred at 12:20 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) RIVER CLUB ESTATES DATE SIGNED 27 Feb 59 ACTUAL SIGNATURE James L Hudson, Jr. PHYSICIAN'S NAME (Type) JAMES I. HUDSON, JR. EDGEWATER MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/28/59	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	22d. LOCATION (City, town, or county) (State) Glen Burnie
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE MAR 2 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

22,63195XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME OR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S&P

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01423

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>	c. LENGTH OF STAY IN 1b <u>4 mo.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maryland House of Correction Hosp.</u>		d. STREET ADDRESS <u>861 Lemon St.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph A Bryan</u>		4. DATE OF DEATH <u>Feb 27 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sep 25 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR <u>5</u> Months <u>3</u> Days <u>5</u> Hours <u>19</u> Min.
13. FATHER'S NAME <u>Marvin Bryan</u>		14. MOTHER'S MAIDEN NAME <u>Albata Tolliver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <u>Mary Bryan</u> Address <u>861 Lemon St</u>	
16. SOCIAL SECURITY NO. <u>213-03-3083</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 392x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-29</u> , 19 <u>57</u> , to <u>2-27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-27</u> , 19 <u>57</u> , and that death occurred at <u>7:40</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jose M. Yosueco</u> M.D.		ADDRESS (Street, city or town, state) <u>RFD #1 Jessup Md</u> DATE SIGNED <u>2-27-57</u>	
PHYSICIAN'S NAME (Type) <u>Jose M. Yosueco</u>		R.F.D. # <u>1</u> <u>Jessup, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>mt Auburn</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A Rice</u> ADDRESS <u>6616 W. Bane St</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 4 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Conrad S. Smith</u>

1444

CERTIFICATE OF DEATH

Reg. Dist. No.

01424

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rt 1 Box 284</i>		1d. STREET ADDRESS <i>Rt 1 Box 284</i>	
3. NAME OF DECEASED (Type or print) First <i>Margaret</i> Middle <i>Elizabeth</i> Last <i>Bull</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>4</i> Year <i>1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-11-1883</i>
9. AGE (In years lost birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>Edgewater, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Vinton Nichols</i>		14. MOTHER'S MAIDEN NAME <i>Alice Purdy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Albert T. Bull</i>		Address <i>Edgewater, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>450x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic vasicular disease</i> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>2 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1-30</i> , 19 <i>59</i> , to <i>2-3</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2-4</i> , 19 <i>59</i> , and that death occurred at <i>6:54</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sylvia M. Lim</i>		ADDRESS (Street, city or town, state) <i>Rt 1 Box 277-M</i> DATE SIGNED <i>2-4-59</i>	
PHYSICIAN'S NAME (Type) <i>Sylvia M. Lim</i>		<i>Edgewater, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>2-7-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mayo Memorial Cent</i>	22d. LOCATION (City, town, or county) (State) <i>Mayo A.C.C. Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Suro</i>		ADDRESS <i>Crimmopolis Md</i>	
24a. REC'D BY REGISTRAR <i>Arthur S. Hanna</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	
DATE <i>FEB 6 '59</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>NEW YORK</i>		5. DATE OF BIRTH <i>1900</i>		6. PLACE OF DEATH <i>Baltimore, Md.</i>	
7. OCCUPATION <i>Engineer</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. DATE OF DEATH <i>1945</i>		11. TIME OF DEATH <i>10:00 AM</i>		12. PLACE OF INTERMENT <i>St. Mary's Cemetery</i>	
13. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. NAME OF FUNERAL HOME <i>St. Mary's</i>		15. NAME OF MINISTER <i>Rev. J. H. Smith</i>	
16. NAME OF NEXT OF KIN <i>John J. Smith</i>		17. ADDRESS OF NEXT OF KIN <i>123 Main St.</i>		18. CITY AND STATE OF NEXT OF KIN <i>Baltimore, Md.</i>	
19. NAME OF DECEASED'S MOTHER <i>John J. Smith</i>		20. NAME OF DECEASED'S FATHER <i>John J. Smith</i>		21. NAME OF DECEASED'S SPOUSE <i>John J. Smith</i>	
22. NAME OF DECEASED'S CHILDREN <i>John J. Smith</i>		23. NAME OF DECEASED'S SIBLINGS <i>John J. Smith</i>		24. NAME OF DECEASED'S PARENTS <i>John J. Smith</i>	
25. NAME OF DECEASED'S GRANDPARENTS <i>John J. Smith</i>		26. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		27. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
28. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		29. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		30. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
31. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		32. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		33. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
34. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		35. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		36. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
37. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		38. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		39. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
40. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		41. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		42. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
43. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		44. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		45. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
46. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		47. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		48. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
49. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		50. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		51. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
52. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		53. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		54. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
55. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		56. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		57. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
58. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		59. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		60. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
61. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		62. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		63. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
64. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		65. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		66. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
67. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		68. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		69. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
70. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		71. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		72. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
73. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		74. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		75. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
76. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		77. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		78. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
79. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		80. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		81. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
82. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		83. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		84. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
85. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		86. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		87. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
88. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		89. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		90. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
91. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		92. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		93. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
94. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		95. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		96. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
97. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		98. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		99. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	
100. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		101. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>		102. NAME OF DECEASED'S GREAT-GRANDPARENTS <i>John J. Smith</i>	

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS AND IS NOT TO BE DESTROYED OR DISPOSED OF IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE COMMISSIONER OF HEALTH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 Film G239 3-2-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

01425

1445

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3001-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Plaza Manor Nursing Home</i>		d. STREET ADDRESS <i>38 S. Bond St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Caldwell</i> Last		4. DATE OF DEATH Month <i>2</i> Day <i>27</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-16-72</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Obee Caldwell</i>		14. MOTHER'S MAIDEN NAME <i>Lucinda</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Charles Guus</i> Address <i>Di 20857</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Atherosclerosis</i> DUE TO <i>Coronary</i> (c) <i>Vascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-14</i> , 1959, to <i>2-21</i> , 1959, that I last saw the deceased alive on <i>2-21</i> , 1959, and that death occurred at <i>11:30</i> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Felix Feunberg</i> M.D.		ADDRESS (Street, city or town, state) <i>P. Box 37 Odenton Md</i> DATE SIGNED <i>2-22-59</i>	
PHYSICIAN'S NAME (Type) <i>Felix Feunberg M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb 26 59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary</i>		22d. LOCATION (City, town, or county) (State) <i>A.A. County Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Milton E. Ellickson</i> ADDRESS <i>1129 N. Caroline St</i>		24a. REC'D BY REGISTRAR <i>FEB 25 59</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G239 2-24-59 et

1446

CERTIFICATE OF DEATH

Reg. Dist. No.

01426

1. PLACE OF DEATH a. COUNTY <u>AA.CO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA.CO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>			c. LENGTH OF STAY IN 1b <u>3 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margarets - Annapolis</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home - St. Margarets</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Regina</u> Middle <u>Carroll</u> Last <u>Carroll</u>				4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>19 59</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1874</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u>84</u> Days <u>84</u> Hours <u>84</u> Min. <u>84</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Richard Not Employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hartford Co MD</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u>Richard Foley</u>			
14. MOTHER'S MAIDEN NAME <u>Lochary</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			
16. SOCIAL SECURITY NO. <u>ANNAPOLIS RD 2 MD</u>				17. INFORMANT <u>MR FRANK J HARRIS</u> Address <u>ANNAPOLIS RD 2 MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis chronic</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>2-10</u> , 19 <u>59</u> , to <u>2-10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-10</u> , 19 <u>59</u> , and that death occurred at <u>12 AM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. <u>Chesapeake DE</u>			
PHYSICIAN'S NAME (Type) <u>E. Linhardt</u>				<u>Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Ignatius Hickory</u>		22d. LOCATION (City, town, or county) (State) <u>Hickory Hartford Co MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Jones</u>				ADDRESS <u>Bel Air Md</u>			
24a. REC'D BY REGISTRAR DATE <u>FEB 13 59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1447 CERTIFICATE OF DEATH

Reg. Dist. No. 27

01427

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft Meade</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u> <u>13X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>				d. STREET ADDRESS <u>Box 272</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM</u> <u>JAMES</u> <u>CARLTON</u>				4. DATE OF DEATH Month Day Year <u>February</u> <u>5</u> <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11 October 1958</u>	
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR: Months <u>24</u> Days <u>24</u> Hours <u>Min.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James E. Carlton</u>				14. MOTHER'S MAIDEN NAME <u>Marie C. Greeno</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>James E. Carlton (father)</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>571.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Electrolyte Imbalance</u> DUE TO (c) <u>Diarrhea</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>2 February, 1959</u> , to <u>5 February, 1959</u> , that I last saw the deceased alive on <u>5 February, 1959</u> , and that death occurred at <u>1000P M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Roger C. Moyer</u>				ADDRESS (Street, city or town, state) <u>U.S. Army Hospital, Ft Meade, Md</u> DATE SIGNED <u>5 Feb 59</u>			
PHYSICIAN'S NAME (Type) <u>ROGER C. MOYER, CAPT, MC.</u>				U. S. ARMY HOSPITAL, FT MEADE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

2050212XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9 Film G239 2-20-59 et

CERTIFICATE OF DEATH

1448

Reg. Dist. No.

01428

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland Park</u> 16x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Crownville State Hospital</u>		d. STREET ADDRESS <u>1207 - 69th Place</u>	
3. NAME OF DECEASED (Type or print) <u>Henrietta</u> First Middle Last		4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/13/1908</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Barnes</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Elizabeth Clark - Daughter, Highland Park</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperpyrexia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebro-vascular - accident - Brain Stem.</u> (c) <u>Hypertensive Cardiovascular Renal Disease.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia - moderate.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/13/1959</u> to <u>2/13/1959</u> , that I last saw the deceased alive on <u>2/13/1959</u> , and that death occurred at <u>9:50 PM</u> , from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <u>Richard M. Henry Mapp</u> M.D.		ADDRESS (Street, city or town, state) <u>Crownville State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Lionel M. Henry Mapp</u>		City <u>Crownville</u> State <u>MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Stewart - 30 H. St.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>FEB 17 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Goss</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES B. BROWN		45		M		W		JAN 15 1880		SEATTLE, WASH.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 5th Ave.		Carpenter		Heart Disease		Natural		JAN 20 1925		SEATTLE, WASH.	
Physician's Signature		Physician's Name		Physician's Address		Physician's Phone		Physician's License No.		Physician's State	
J. B. Smith		J. B. Smith		1234 5th Ave.		1234 5th Ave.		1234 5th Ave.		1234 5th Ave.	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Date		Burial Time	
Crematorium		JAN 22 1925		10:00 AM		Crematorium		JAN 22 1925		10:00 AM	
Funeral Home		Funeral Date		Funeral Time		Funeral Place		Funeral Date		Funeral Time	
Funeral Home		JAN 22 1925		10:00 AM		Funeral Home		JAN 22 1925		10:00 AM	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Date		Burial Time	
Crematorium		JAN 22 1925		10:00 AM		Crematorium		JAN 22 1925		10:00 AM	
Funeral Home		Funeral Date		Funeral Time		Funeral Place		Funeral Date		Funeral Time	
Funeral Home		JAN 22 1925		10:00 AM		Funeral Home		JAN 22 1925		10:00 AM	

ADULTS
JAMES B. BROWN
JAN 20 1925
SEATTLE, WASH.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01429

Reg. Dist. No.

1449

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Conn.</u> b. COUNTY <u>Southbury</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Southbury Conn</u>		c. LENGTH OF STAY IN 1b <u>8 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Arnold md.</u>		d. STREET ADDRESS <u>45x-3</u>	
3. NAME OF DECEASED (Type or print) <u>James Edward Coer</u>		4. DATE OF DEATH <u>Feb 12 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 31, 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Waterbury Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Edward Coer</u>		14. MOTHER'S MAIDEN NAME <u>Ellen C. Walton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Son Milton E. Coer</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> 159X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Carcinomatosis</u> DUE TO (c) <u>Arteriosclerosis C.V. Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 2-11-59</u> , 1958, to <u>2-12-59</u> , 1959, that I last saw the deceased alive on <u>2-11-59</u> , 1959, and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u>		ADDRESS (Street, city or town, state) <u>Severna Park md</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>		DATE SIGNED <u>2-12-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2-16-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pine Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Southbury Conn</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm F Haggins Jr Annapolis md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>FEB 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1413

CERTIFICATE OF DEATH

01430

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Edgewater Beach	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian First L. Middle CORNWELL Last		4. DATE OF DEATH FEB Month 6 Day 19 Year 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/11/73
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? Virginia	
13. FATHER'S NAME John B. Davis		14. MOTHER'S MAIDEN NAME Cecil R. Hickson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Fred C. Cornwell-9014	
17. INFORMANT Fred C. Cornwell-9014		Address Silver Spring, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic coronary heart disease 10 years DUE TO gen. arteriosclerosis pulmonary edema (c) gen. arteriosclerosis pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-6 , 19 59 , to 2-6 , 19 59 , that I last saw the deceased alive on 2-5 , 19 59 , and that death occurred at 440 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 45 FRANKLIN ST. ANNAPOLIS, MD DATE SIGNED 2-6-59			
ACTUAL SIGNATURE Edith Rodler M.D.		PHYSICIAN'S NAME (Type) EDITH RODLER M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/59	
22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		ADDRESS Washington D. C.	
24a. RECEIVED BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE William E. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO LIBRARY

1450
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 2yr. 4mo. 24days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 129 Amity Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bud		4. DATE OF DEATH Month 2 Day 18 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December, 1883
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Davis		14. MOTHER'S MAIDEN NAME Hallie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-0735	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 002X (b) Arteriosclerotic Cardiovascular-Renal Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tuberculosis, Pulmonary-far advanced			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/24 , 19 56 , to 2/18 , 19 59 , that I last saw the deceased alive on 2/18 , 19 59 , and that death occurred at 6:30A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville State Hospital, M.D. DATE SIGNED 2/18/59	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		Crownsville State Hospital, M. D. 2/18/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23, 1959	
22c. NAME OF CEMETERY OR CREMATORY McAuburn Cem.		22d. LOCATION (City, town, or county) (State) Ba/To. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie R. Williams		24a. REC'D BY REGISTRAR FEB 19 '59	
ADDRESS 322 N. Schrock St		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1414
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				d. STREET ADDRESS <u>Route 1, Box 30A</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 February 1959</u>		9. AGE (In years last birthday) yrs. <u>4</u> Min. <u>13</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — — —			10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Sperry David DAVIS</u>				14. MOTHER'S MAIDEN NAME <u>Rosetta Lucile ROLLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. — — —		17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYALINE MEMBRANE DISEASE</u> <u>773.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>19</u> p. m.	Month <u>—</u> Day <u>—</u> Year <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>18 February, 19 59</u> , to <u>18 February, 19 59</u> , that I last saw the deceased alive on <u>18 February, 19 59</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. M. KENNY</u> M.D.				ADDRESS (Street, city or town, state) <u>U.S. NAVAL HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>F. M. KENNY LT MC USNR</u>				DATE SIGNED <u>2-19-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Naval Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneave</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051364XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01433

1415

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S.N. Hospital, Annapolis, Md.</u>		d. STREET ADDRESS <u>163 Prince George Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Agostino</u> Middle <u>(n)</u> Last <u>DiMAGGIO</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>23</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-78</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Gregory DiMAGGIO</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth NELLI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I</u>	
17. INFORMANT <u>U.S. Naval Hospital Annapolis, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>21 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-23</u> , 19 <u>59</u> , to <u>2-23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-23</u> , 19 <u>59</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. J. Bunn</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>2-24-59</u>	
PHYSICIAN'S NAME (Type) <u>H. I. HOCHMAN I.T. MC USN</u>		M.D. <u>U.S. Naval Hospital, Anna. Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-26-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur M. Taylor</u>		24a. REC'D BY REGISTRAR <u>Feb 26 '59</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>				c. LENGTH OF STAY IN 1b <u>6 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Telegraph Rd.</u>				d. STREET ADDRESS <u>Same</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Ruby Edith Ergott</u>				4. DATE OF DEATH Month Day Year <u>February 6th 19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/92</u>	9. AGE (In years last birthday) yrs. <u>66</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Tammarach Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Johnethon Miller</u>				14. MOTHER'S MAIDEN NAME <u>Marguerite Tomb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Sara Johnson (daughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypertensive cardio vascular diseases</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 y.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August 7th, 1955</u> , to <u>Feb 7th, 1959</u> , that I last saw the deceased alive on <u>2/6/59</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gustave H. Feubert, M.D.</u>				ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u>		DATE SIGNED <u>2/7/59</u>	
PHYSICIAN'S NAME (Type) <u>Gustave H. Feubert, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jersey Shore Cemetery, Lyeomg Co., Pa.</u>		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley, Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1452

CERTIFICATE OF DEATH

01435

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>				c. LENGTH OF STAY IN 1b <i>51 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>Rt 1 Box</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Franklin</i> Last <i>EVANS</i>				4. DATE OF DEATH Month <i>2</i> - Day <i>7</i> - Year <i>1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 5th 1873</i>	
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months <i>85</i> Days <i>85</i> Hours <i>85</i> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman & Carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>(Retired)</i>		11. BIRTHPLACE (State or foreign country) <i>Riva, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Charles W. EVANS,</i>				14. MOTHER'S MAIDEN NAME <i>Madora (Maiden Name ?)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-18-8710</i>		17. INFORMANT <i>George F. EVANS,</i>		Address <i>Edgewater, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO <i>Congestive cardiac failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardio-vascular disease</i> (c) <i>disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7-26</i> , 19 <i>58</i> , to <i>2-6</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2-7</i> , 19 <i>59</i> , and that death occurred at <i>3:40 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Sylvia M. Lim</i>				ADDRESS (Street, city or town, state) <i>Rt 1 Box 277-M Edgewater, Md.</i>			
DATE SIGNED <i>2-7-59</i>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>Feb 9, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Memorial</i>		22d. LOCATION (City, town, or county) (State) <i>ANNAPOLIS, MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>T A Hardesty & Son</i>				ADDRESS <i>Galesville, Md</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 11 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1453

CERTIFICATE OF DEATH

01436

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY in 1b <u>6mo. 4days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>			d. STREET ADDRESS <u>1400 E. fairmount Avenue</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Evans</u> Last <u>Evans</u>			4. DATE OF DEATH Month <u>2/</u> Day <u>12</u> Year <u>1959</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>5/10/81</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>219-03-1686</u>		
17. INFORMANT <u>Hospital Records</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>syphilitic & Arteriosclerotic Cardiovascular</u> <u>023X</u> DUE TO <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>		
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>			20f. (City or town) (County) (State) <u>-----</u>		
21. I certify that I attended the deceased from <u>8/8</u> , 19 <u>58</u> , to <u>2/12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/12</u> , 19 <u>59</u> , and that death occurred at <u>4:55A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>2/13/59</u> ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. <u>2/13/59</u> PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> <u>Crownsville State Hospital, Md.</u> <u>2/13/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>University of Md</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>			24a. REC'D BY REGISTRAR DATE <u>FEB 16 1959</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1454

CERTIFICATE OF DEATH

01437

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Glenn John</u> <u>2352 Middle First</u> Last <u>St.</u>		4. DATE OF DEATH <u>Feb. 26</u> 19 <u>59</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 5 1879</u> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Boston Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jessie Glenn</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Johnson Glenn Jr.</u> Address <u>Severna Park, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C.V. Disease</u> DUE TO (c) <u>Generalized Atherosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-25-59</u> , 19 <u>59</u> , to <u>2-26-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-27-59</u> , 19 <u>59</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>Feb 26 59</u>	
PHYSICIAN'S NAME (Type) <u>Robert B. HAHN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-1-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Town Neck</u>	22d. LOCATION (City, town, or county) (State) <u>Severna Park, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u> ADDRESS <u>Cumma, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 3 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1455

CERTIFICATE OF DEATH

01438

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anne Arundel</u> c. LENGTH OF STAY IN 1b <u>2 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Linstead on the Severn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> d. STREET ADDRESS <u>Linstead on the Severn</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>LOUISE</u> Last <u>GOSNELL</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>13</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 29, 1882</u>	
9. AGE (In years last birthday) yrs. <u>76</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hostess (ret.)</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Johns Hopkins</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles A. Gosnell</u>	
14. MOTHER'S MAIDEN NAME <u>Tamsey R. Horan</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>//////////</u>		17. INFORMANT <u>Mr. Charles M. Gosnell, Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>722.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatoid Arthritis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>20 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 13, 1959</u> , to <u>Feb. 13, 1959</u> , that I last saw the deceased alive on <u>Feb. 13, 1959</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>James S. Billingslea</u> M.D. <u>108 Central Ave., N.W.</u> DATE SIGNED <u>2/14/59</u> PHYSICIAN'S NAME (Type) <u>James S. Billingslea</u> <u>Glen Burnie, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 19 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

75

CERTIFICATE OF DEATH

Reg. Dist. No.

1416

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>64 Highland Court</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>ROBERT</u> Last <u>GRAY SR</u>				4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1898</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Manf. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mr. H.M. Gray Jr. - Son - Havre De Grace, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 PM 2/19/59</u> , to <u>11 PM 2/19/59</u> , that I last saw the deceased alive on <u>2/19/59</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Hedeman</u> M.D.				ADDRESS (Street, city or town, state) <u>121 Cathedral</u>		DATE SIGNED <u>2/19/59</u>	
PHYSICIAN'S NAME (Type) <u>John Hedeman MD</u>				<u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 23, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grace Lawn Mem. Park Silverbrook Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Farmhurst Wilmington, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. This is a duplicate of the original of the Maryland State Department of Health - Baltimore 18

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

PLACE IN DATE		DATE	
A. DEATH		A. DEATH	
B. DEATH		B. DEATH	
C. DEATH		C. DEATH	
D. DEATH		D. DEATH	
E. DEATH		E. DEATH	
F. DEATH		F. DEATH	
G. DEATH		G. DEATH	
H. DEATH		H. DEATH	
I. DEATH		I. DEATH	
J. DEATH		J. DEATH	
K. DEATH		K. DEATH	
L. DEATH		L. DEATH	
M. DEATH		M. DEATH	
N. DEATH		N. DEATH	
O. DEATH		O. DEATH	
P. DEATH		P. DEATH	
Q. DEATH		Q. DEATH	
R. DEATH		R. DEATH	
S. DEATH		S. DEATH	
T. DEATH		T. DEATH	
U. DEATH		U. DEATH	
V. DEATH		V. DEATH	
W. DEATH		W. DEATH	
X. DEATH		X. DEATH	
Y. DEATH		Y. DEATH	
Z. DEATH		Z. DEATH	

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1456

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital				d. STREET ADDRESS Box 222			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CRAIG Middle Renard Last GRIFFIN				4. DATE OF DEATH Month February Day 25 Year 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 November 1958		9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months 2 Days 26	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Griffin				14. MOTHER'S MAIDEN NAME Geraldine M. Snipes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Hospital Records Address U.S. Army Hosp, Ft Meade, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumothorax DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 day 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 Feb 19 59 , to 25 Feb 19 59 , that I last saw the deceased alive on 25 Feb 19 59 , and that death occurred at 4:53P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Army Hospital, Ft Meade, Md 25 Feb 59							
ACTUAL SIGNATURE Fred W. Lafferty				M.D. U.S. Army Hospital, Ft Meade, Md			
PHYSICIAN'S NAME (Type) FRED W. LAFFERTY, CAPT, MC				U.S. Army Hospital, Ft Meade, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park		22d. LOCATION (City, town, or county) (State) Prince George County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE EIROY O. WILSON				ADDRESS FUNERAL HOME 1000 Brantley Ave.		24a. REC'D BY REGISTRAR DATE MAR 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2050201XV5

CERTIFICATE OF DEATH

01441

Reg. Dist. No.

1417

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS - Box 1048</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL Gen. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS <u>RT. 3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CALVIN - GROSS - ALIAS CALVERT</u>				4. DATE OF DEATH Month Day Year <u>2 - 23 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 9 - 1902</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>A. A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Gross</u>				14. MOTHER'S MAIDEN NAME <u>MARY P. MILES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W. W. I</u>		INFORMANT Address <u>RT. 3 - Box ANNA, MD 048</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>HEUTE PULMONARY EDEMA</u> DUE TO <u>Arterial Hypertension Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>May 58</u> , to <u>Feb 24 59</u> , that I last saw the deceased alive on <u>Feb 24 59</u> , and that death occurred at <u>5:45 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Richardson</u>		M.D. <u>110 - CLAY ST ANNAPOLIS MD</u>		DATE SIGNED <u>2/24/59</u>			
PHYSICIAN'S NAME (Type) <u>R. L. Richardson</u>		<u>110 CLAY ST. ANNA, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-26-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ANNAPOLIS - NECK</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES E. HICKS</u>		ADDRESS <u>ANNAPOLIS - MD.</u>		24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hicks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1111

RECEIVED OF BANK

1111

AMOUNT OF \$100.00

PAID TO THE ORDER OF

THE BANK OF AMERICA

NEW YORK, N.Y.

DATE

1900

BY

THE BANK OF AMERICA

NEW YORK, N.Y.

DATE

1900

BY

THE BANK OF AMERICA

NEW YORK, N.Y.

DATE

CERTIFICATE OF DEATH

02625

Reg. Dist. No.

1457

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b omo 20days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore?		3. NAME OF DECEASED (Type or print) John		4. DATE OF DEATH Month 2		Day 27		Year 19 59			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1918		9. AGE (In years last birthday) yrs. 40		IF UNDER 1 YEAR Months 40		IF UNDER 24 HRS. Days 27		Hours 19		Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Gwaltney		14. MOTHER'S MAIDEN NAME Otelia		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of Esophagus DUE TO (c)																				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abscess of Brain																				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----																			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----		(State) -----											
21. I certify that I attended the deceased from 8/7 , 19 58 , to 2/27 , 19 59 , that I last saw the deceased alive on 2/27 , 19 59 , and that death occurred at 8:50A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 2/27/59 ACTUAL SIGNATURE L. Benedict, M. D. M.D. Crownsville State Hospital, Md. 2/27/59 PHYSICIAN'S NAME (Type) L. Benedict, M. D. Crownsville State Hospital, Md. 2/27/59																					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-59		22c. NAME OF CEMETERY OR CREMATORY Hospital Grounds		22d. LOCATION (City, town, or county) Crownsville, Md.		(State) -----													
23. FUNERAL DIRECTOR'S SIGNATURE Adrian S. Kneass		ADDRESS Crownsville, Md.		24a. REC'D BY REGISTRAR MAR 13 '59		24b. REGISTRAR'S SIGNATURE Adrian S. Kneass															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1418

CERTIFICATE OF DEATH

01442

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,				c. LENGTH OF STAY IN 1b 30 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Aloysius Last Haley Sr.				4. DATE OF DEATH Month February Day 28 Year 1959			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1870 Nov. 14, 1868	
9. AGE (In years last birthday) 88 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofing Contractor		10b. KIND OF BUSINESS OR INDUSTRY Roofing Contractor		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME James (n) Haley		14. MOTHER'S MAIDEN NAME Sebina McManus			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1898-1899		16. SOCIAL SECURITY NO. 220-05-0496		17. INFORMANT James A. Haley Jr. Address 96 Duke of Gloucester St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 4 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 28 Feb. 1959 , to 28 Feb. 1959 , that I last saw the deceased alive on 28 Feb. 1959 , and that death occurred at 1025 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, Annapolis, Maryland DATE SIGNED _____							
ACTUAL SIGNATURE [Signature] M.D. U. S. Naval Hospital, Annapolis, Maryland							
PHYSICIAN'S NAME (Type) M. J. MILLER LT (MC) USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		3-4-59		ARLINGTON NATIONAL		ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Lott + Sons				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE MAR 4 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1918

Name of Deceased		Date of Birth	
John Doe		Jan 1, 1880	
Sex		Age	
Male		38	
Race		Color	
White		White	
Place of Birth		Date of Death	
Baltimore, Md.		Jan 15, 1918	
Cause of Death		Place of Death	
Heart Disease		Home	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Coronary Atherosclerosis	
Duration of Illness		Time of Day	
10 Days		10:00 AM	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date		Place	
Jan 15, 1918		Baltimore, Md.	

CERTIFICATE OF DEATH

01443

Reg. Dist. No. 27

1458

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G. Meade, Md</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				d. STREET ADDRESS <u>17 Admiral Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>O (Newman)</u> Last <u>Hanks</u>				4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 4, 1878</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>William E. Newman</u>				14. MOTHER'S MAIDEN NAME <u>(Unknown) Corker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Col. Ovid Forman, 17 Admiral Rd, Severna Park, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u> <u>unknown</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>15 May</u> , 19 <u>58</u> , to <u>6 Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6 February</u> , 19 <u>59</u> , and that death occurred at <u>1000</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 Feb 59</u> DATE SIGNED							
ACTUAL SIGNATURE <u>George B. Hagan, Capt, MC</u> M.D. U.S. Army Hospital, Ft George G. Meade, Md.							
PHYSICIAN'S NAME (Type) <u>GEORGE B. HAGAN, CAPT., MC</u> U. S. Army Hospital, Ft George G. Meade, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. Worth, Texas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balt 17</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1419

CERTIFICATE OF DEATH

Reg. Dist. No.

01444

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>V</u> Last <u>HARDESTY</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>8</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1900</u>
9. AGE (In years last birthday) <u>58 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anton Steiner</u>		14. MOTHER'S MAIDEN NAME <u>Annie Harold</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Joseph Mayr-Daughter- same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia + anuresis</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic - Stiff - Kidney</u> DUE TO <u>1 1/2 yrs.</u> (c) <u>Diabetes</u> DUE TO <u>10 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cytotoxic, surgically absent kidney</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>2-8-1959</u> , that I last saw the deceased alive on <u>2-8-1959</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Shipley</u>		M.D. <u>221 Cathedral St</u> DATE SIGNED <u>2-10-59</u>	
PHYSICIAN'S NAME (Type) <u>Frank Shipley</u>		MD <u>Annapolis, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 11, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>All Hallows Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Davidsonville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Feb 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES	
JAMES J. JONES		M		45		1880		NEW YORK		Carpenter		Heart Disease		Home		10:00 AM		[Signature]		[Signature]		[Signature]	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. NAME OF MINISTER		17. NAME OF CHURCH		18. NAME OF FUNERAL HOME		19. NAME OF CEMETERY		20. NAME OF CITY		21. NAME OF STATE		22. NAME OF COUNTY		23. NAME OF TOWN		24. NAME OF VILLAGE	
St. Mary's Church		St. Mary's Church		1925		Rev. J. J. Jones		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church		St. Mary's Church	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
JANUARY 1925
[Additional text and stamps on the right margin]

1459

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Margarets</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x St Margarets</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Logan Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Marysia</i> Middle <i>C</i> Last <i>Hays</i>		4. DATE OF DEATH Month <i>2</i> Day <i>5</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 30-1893</i>
9. AGE (In years last birthday) <i>63</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	
11. BIRTHPLACE (State or foreign country) <i>Sparrows Pt. Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Frank Kirk</i>		14. MOTHER'S MAIDEN NAME <i>Sophie Lunther</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Oscar G. Hays</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic cardiovascular disease i hypertension</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>15 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Ann</i> , 1940, to <i>Feb 5</i> , 1959, that I last saw the deceased alive on <i>Feb 4</i> , 1959, and that death occurred at <i>1:15 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>S. Borssuck</i> M.D. <i>Amor G. Guedes</i> <i>2/7/59</i>			
PHYSICIAN'S NAME (Type) <i>S. Borssuck</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-8-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial</i>	22d. LOCATION (City, town, or county) (State) <i>Glen Burnie Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Sayla Sr</i> ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR <i>FEB 9 59</i>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>Life time</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Earleigh Heights Rd.</u>		d. STREET ADDRESS <u>Same</u>	
3. NAME OF DECEASED (Type or print) <u>Bernette Henson</u> First <u>E. Henson</u> Middle Last		4. DATE OF DEATH <u>February 12th.</u> 19 <u>59</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/8/54</u>
9. AGE (In years last birthday) <u>5</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Earleigh Heights, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Usa</u>	
13. FATHER'S NAME <u>Bernard Hensen</u>		14. MOTHER'S MAIDEN NAME <u>Grace Henson Trivins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Grace Henson (mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Charred above recognition</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was in bed when home caught on fire. Second floor.</u>	
20c. TIME OF INJURY Month, Day, Year <u>2.40</u> a. m. <u>2/12/59</u> 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Severna Park A.A. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		DATE SIGNED <u>2/12/59</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-15-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>First Baptist Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Earleigh Hgts., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson, Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

NEW YORK
COUNTY
CITY OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
100 NASSAU ST.
NEW YORK 1

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
100 NASSAU ST.
NEW YORK 1

1. NAME OF DECEASED: [REDACTED]
2. SEX: [REDACTED]
3. AGE: [REDACTED]
4. DATE OF BIRTH: [REDACTED]
5. PLACE OF BIRTH: [REDACTED]
6. OCCUPATION: [REDACTED]
7. CAUSE OF DEATH: [REDACTED]
8. PLACE OF DEATH: [REDACTED]
9. DATE OF DEATH: [REDACTED]
10. TIME OF DEATH: [REDACTED]
11. SIGNATURE OF REGISTRAR: [REDACTED]
12. SIGNATURE OF PHYSICIAN: [REDACTED]
13. SIGNATURE OF MORTUARY: [REDACTED]
14. SIGNATURE OF FUNERAL HOME: [REDACTED]
15. SIGNATURE OF BURIAL: [REDACTED]
16. SIGNATURE OF CREMATION: [REDACTED]
17. SIGNATURE OF OTHER: [REDACTED]
18. SIGNATURE OF OTHER: [REDACTED]
19. SIGNATURE OF OTHER: [REDACTED]
20. SIGNATURE OF OTHER: [REDACTED]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01447

1461

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 13yr.6m lda. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS ? e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charles E. Hill			4. DATE OF DEATH Month 2 Day 10 Year 1959		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1907		9. AGE (In years last birthday) 52+
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 434.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Constrictive Pericarditis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown		
20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown		20f. (City or town) (County) (State) Unknown
21. I certify that I attended the deceased from 8/9 , 19 45 to 2/10 , 19 59 , that I last saw the deceased alive on 2/10 , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 2/10/59 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. Crownsville State Hospital, Md. 2/10/59 PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md. 2/10/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Feb. 14-59		22b. DATE THEREOF Feb. 14-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph H. Locks Jr.		ADDRESS 1304 N Central Ave.		24a. REC'D BY REGISTRAR DATE FEB 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

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1462

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Conn.</u> b. COUNTY <u>Middlesex Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riva</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown 45x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MANOR Guest HOUSE</u>		d. STREET ADDRESS <u>High St.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>C.</u> Last <u>HILL</u>		4. DATE OF DEATH Month <u>February</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22-1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Conn.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Abraham Crosley</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Footitt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Joseph Crosley</u>		Address <u>Kang Geo St Annapolis, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/3</u> , 19 <u>59</u> , to <u>2/4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/3</u> , 19 <u>59</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Reier</u>		DATE SIGNED <u>2/4/59</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. REIER</u>		ADDRESS (Street, city or town, state) <u>120 CATHEDRAL ST ANNAPOLIS, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St John Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Middletown Conn</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24. REC'D BY REGISTRAR <u>DATE FEB 6 '59</u>	
ADDRESS <u>Annapolis, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1463

CERTIFICATE OF DEATH

01449

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nathanial Jones		4. DATE OF DEATH Month Day Year 2 14 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1885
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 023x DUE TO Terminal Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Syphilitic Cardiovascular Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Stomach			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour 10:45A p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/27 , 19 59 , to 2/14 , 19 59 , that I last saw the deceased alive on 2/14 , 19 59 , and that death occurred at 10:45A , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp, M.D.		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 2/16/59	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.		ADDRESS Crownsville State Hospital, Md. 2/16/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-59	
22c. NAME OF CEMETERY OR CREMATORY Hosp. Grounds		22d. LOCATION (City, town, or county) (State) Crownsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Howard		ADDRESS Crownsville, Md.	
24a. REC'D BY REGISTRAR FEB 26 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

01450

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WATER OAK POINT - PASADENA</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>AA.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <u>PASADENA - MD.</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>J</u> Last <u>MAINE</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>MALE</u> <u>WHITE</u>		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-30-1891</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>THOMAS</u>				14. MOTHER'S MAIDEN NAME <u>MAGGIE HETCHEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/19</u> , 19 <u>58</u> , to <u>2/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/14</u> , 19 <u>59</u> , and that death occurred at <u>10:20 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Rivers Beach</u>		DATE SIGNED <u>2/16/59</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>				ADDRESS <u>Pasadena Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-19-59</u>		<u>HOLY ROSARY</u>		<u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Gogowski</u>				ADDRESS <u>1930 Eastern Ave</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 17 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Brown</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01451

Reg. Dist. No.

1420

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>9 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. Gen. Hospital</u>			d. STREET ADDRESS		e. IS RESIDENCE ON FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Katherine</u> First Middle Last			4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-88</u>	9. AGE (In years last birthday) <u>70</u> rs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Catonsville</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>John Kroner</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT Address <u>Son in law. Catonsville Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive burn, 2nd, 3rd degree</u> <u>916.0</u> DUE TO <u>entire body</u> Conditions, if any, which gave rise to immediate cause (b) <u>9 hours</u> (c) <u>entire body</u> gave rise to immediate cause (a), stating the underlying cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in house fire</u>		20c. TIME OF INJURY Month, Day, Year <u>2-20-59</u> Hour <u>1</u> a.m. <u>1</u> p.m.			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. City or town <u>Millersville</u> (County) <u>A.A.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Elmer Linhardt</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Elmer Linhardt</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>2-20-59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Catonsville</u>		(State) <u>Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Hall</u>	
ADDRESS <u>Mac Hall & Son</u>		24a. REC'D BY REGISTRAR <u>FEB 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1465

CERTIFICATE OF DEATH

01452

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Ind. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town) Deale		c. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town) Deale Ind.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Deale Ind.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle I. Last Kent		4. DATE OF DEATH Month Feb Day 11 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 27 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 11 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Sub. Contractor & Wood Co. D.C.	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Benjamin F. Kent		14. MOTHER'S MAIDEN NAME Letitia Maley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 223-28-3792	
17. INFORMANT Mrs. William Carter		Address 720 S. 15th Place, Baltimore	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 11 1958 to Feb 11 1959 , that I last saw the deceased alive on 11 Feb 1958 , and that death occurred at 12:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. B. Sasscer		M.D. Upper Marlboro Md 11-2-59	
PHYSICIAN'S NAME (Type) R. B. Sasscer, M. D.		ADDRESS (Street, city or town, state) Upper Marlboro, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/14/59	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Church Cem.		22d. LOCATION (City, town, or county) (State) Remo Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR FEB 17 '59	
24b. REGISTRAR'S SIGNATURE William S. Carter			

CERTIFICATE OF DEATH

1902

NAME OF DECEASED *John Doe* SEX *M* AGE *45* OCCUPATION *Farmer*

DATE OF DEATH *Jan 15 1902* PLACE OF DEATH *Home*

CAUSE OF DEATH *Heart Disease*

PLACE OF BURIAL *St. Mary's Cemetery*

SIGNATURE OF PHYSICIAN *J. H. Smith*

SIGNATURE OF MINISTER *W. B. Jones*

SIGNATURE OF CORONER *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

SIGNATURE OF JURY *W. B. Jones*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01453

1466

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> ✓			
c. LENGTH OF STAY IN 1b <u>2mo. 18 days</u>				d. STREET ADDRESS <u>613 Cornell Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Julian</u> Middle <u>King</u> Last <u>King</u>			4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1900</u>	9. AGE (In years lost birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John King</u>			14. MOTHER'S MAIDEN NAME <u>Mary Bean</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor pulmonale</u> <u>502.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Asthma with Chronic Bronchitis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from <u>11/21</u> , <u>1958</u> , to <u>2/15</u> , <u>1959</u> , that I last saw the deceased alive on <u>2/15</u> , <u>1959</u> , and that death occurred at <u>5:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, and state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp, M.D.</u>				M.D. <u>Crownsville State Hospital, Md.</u> <u>2/16/59</u>			
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u>				M.D. <u>Crownsville State Hospital, Md.</u> <u>2/16/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hosp. Grounds</u>		22d. LOCATION (City, town, or county) (State) <u>Crownsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thomas</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01454

1421

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10</u> <u>Annapolis</u>		d. STREET ADDRESS <u>915 Tyler Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> <u>KLYMAN</u>				4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 7, 1898</u>		9. AGE (in years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Forman- Const.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Const.</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Klyman</u>				14. MOTHER'S MAIDEN NAME <u>Gussie (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural causes</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>8:45</u> a. m. <u>Feb. 19 19 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Annapolis A.A. Maryland</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>				DATE SIGNED <u>February 19, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 20, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kneseth Israel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				24a. REC'D BY REGISTRAR <u>FEB 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. CAUSE OF DEATH: _____

8. MANNER OF DEATH: _____

9. SIGNATURE OF MEDICAL EXAMINER: _____

10. DATE OF EXAMINATION: _____

11. PLACE OF EXAMINATION: _____

12. SIGNATURE OF WITNESS: _____

13. DATE OF SIGNATURE: _____

14. PLACE OF SIGNATURE: _____

15. SIGNATURE OF CORONER: _____

16. DATE OF SIGNATURE: _____

17. PLACE OF SIGNATURE: _____

18. SIGNATURE OF JURY: _____

19. DATE OF SIGNATURE: _____

20. PLACE OF SIGNATURE: _____

21. SIGNATURE OF JUDGE: _____

22. DATE OF SIGNATURE: _____

23. PLACE OF SIGNATURE: _____

24. SIGNATURE OF CLERK: _____

25. DATE OF SIGNATURE: _____

26. PLACE OF SIGNATURE: _____

27. SIGNATURE OF SHERIFF: _____

28. DATE OF SIGNATURE: _____

29. PLACE OF SIGNATURE: _____

30. SIGNATURE OF DEPUTY SHERIFF: _____

31. DATE OF SIGNATURE: _____

32. PLACE OF SIGNATURE: _____

33. SIGNATURE OF CONSTABLE: _____

34. DATE OF SIGNATURE: _____

35. PLACE OF SIGNATURE: _____

36. SIGNATURE OF DEPUTY CONSTABLE: _____

37. DATE OF SIGNATURE: _____

38. PLACE OF SIGNATURE: _____

39. SIGNATURE OF JURY: _____

40. DATE OF SIGNATURE: _____

41. PLACE OF SIGNATURE: _____

42. SIGNATURE OF JUDGE: _____

43. DATE OF SIGNATURE: _____

44. PLACE OF SIGNATURE: _____

45. SIGNATURE OF CLERK: _____

46. DATE OF SIGNATURE: _____

47. PLACE OF SIGNATURE: _____

48. SIGNATURE OF SHERIFF: _____

49. DATE OF SIGNATURE: _____

50. PLACE OF SIGNATURE: _____

51. SIGNATURE OF DEPUTY SHERIFF: _____

52. DATE OF SIGNATURE: _____

53. PLACE OF SIGNATURE: _____

54. SIGNATURE OF CONSTABLE: _____

55. DATE OF SIGNATURE: _____

56. PLACE OF SIGNATURE: _____

57. SIGNATURE OF DEPUTY CONSTABLE: _____

58. DATE OF SIGNATURE: _____

59. PLACE OF SIGNATURE: _____

60. SIGNATURE OF JURY: _____

61. DATE OF SIGNATURE: _____

62. PLACE OF SIGNATURE: _____

63. SIGNATURE OF JUDGE: _____

64. DATE OF SIGNATURE: _____

65. PLACE OF SIGNATURE: _____

66. SIGNATURE OF CLERK: _____

67. DATE OF SIGNATURE: _____

68. PLACE OF SIGNATURE: _____

69. SIGNATURE OF SHERIFF: _____

70. DATE OF SIGNATURE: _____

71. PLACE OF SIGNATURE: _____

72. SIGNATURE OF DEPUTY SHERIFF: _____

73. DATE OF SIGNATURE: _____

74. PLACE OF SIGNATURE: _____

75. SIGNATURE OF CONSTABLE: _____

76. DATE OF SIGNATURE: _____

77. PLACE OF SIGNATURE: _____

78. SIGNATURE OF DEPUTY CONSTABLE: _____

79. DATE OF SIGNATURE: _____

80. PLACE OF SIGNATURE: _____

81. SIGNATURE OF JURY: _____

82. DATE OF SIGNATURE: _____

83. PLACE OF SIGNATURE: _____

84. SIGNATURE OF JUDGE: _____

85. DATE OF SIGNATURE: _____

86. PLACE OF SIGNATURE: _____

87. SIGNATURE OF CLERK: _____

88. DATE OF SIGNATURE: _____

89. PLACE OF SIGNATURE: _____

90. SIGNATURE OF SHERIFF: _____

91. DATE OF SIGNATURE: _____

92. PLACE OF SIGNATURE: _____

93. SIGNATURE OF DEPUTY SHERIFF: _____

94. DATE OF SIGNATURE: _____

95. PLACE OF SIGNATURE: _____

96. SIGNATURE OF CONSTABLE: _____

97. DATE OF SIGNATURE: _____

98. PLACE OF SIGNATURE: _____

99. SIGNATURE OF DEPUTY CONSTABLE: _____

100. DATE OF SIGNATURE: _____

101. PLACE OF SIGNATURE: _____

102. SIGNATURE OF JURY: _____

103. DATE OF SIGNATURE: _____

104. PLACE OF SIGNATURE: _____

105. SIGNATURE OF JUDGE: _____

106. DATE OF SIGNATURE: _____

107. PLACE OF SIGNATURE: _____

108. SIGNATURE OF CLERK: _____

109. DATE OF SIGNATURE: _____

110. PLACE OF SIGNATURE: _____

111. SIGNATURE OF SHERIFF: _____

112. DATE OF SIGNATURE: _____

113. PLACE OF SIGNATURE: _____

114. SIGNATURE OF DEPUTY SHERIFF: _____

115. DATE OF SIGNATURE: _____

116. PLACE OF SIGNATURE: _____

117. SIGNATURE OF CONSTABLE: _____

118. DATE OF SIGNATURE: _____

119. PLACE OF SIGNATURE: _____

120. SIGNATURE OF DEPUTY CONSTABLE: _____

121. DATE OF SIGNATURE: _____

122. PLACE OF SIGNATURE: _____

123. SIGNATURE OF JURY: _____

124. DATE OF SIGNATURE: _____

125. PLACE OF SIGNATURE: _____

126. SIGNATURE OF JUDGE: _____

127. DATE OF SIGNATURE: _____

128. PLACE OF SIGNATURE: _____

129. SIGNATURE OF CLERK: _____

130. DATE OF SIGNATURE: _____

131. PLACE OF SIGNATURE: _____

132. SIGNATURE OF SHERIFF: _____

133. DATE OF SIGNATURE: _____

134. PLACE OF SIGNATURE: _____

135. SIGNATURE OF DEPUTY SHERIFF: _____

136. DATE OF SIGNATURE: _____

137. PLACE OF SIGNATURE: _____

138. SIGNATURE OF CONSTABLE: _____

139. DATE OF SIGNATURE: _____

140. PLACE OF SIGNATURE: _____

141. SIGNATURE OF DEPUTY CONSTABLE: _____

142. DATE OF SIGNATURE: _____

143. PLACE OF SIGNATURE: _____

144. SIGNATURE OF JURY: _____

145. DATE OF SIGNATURE: _____

146. PLACE OF SIGNATURE: _____

147. SIGNATURE OF JUDGE: _____

148. DATE OF SIGNATURE: _____

149. PLACE OF SIGNATURE: _____

150. SIGNATURE OF CLERK: _____

151. DATE OF SIGNATURE: _____

152. PLACE OF SIGNATURE: _____

153. SIGNATURE OF SHERIFF: _____

154. DATE OF SIGNATURE: _____

155. PLACE OF SIGNATURE: _____

156. SIGNATURE OF DEPUTY SHERIFF: _____

157. DATE OF SIGNATURE: _____

158. PLACE OF SIGNATURE: _____

159. SIGNATURE OF CONSTABLE: _____

160. DATE OF SIGNATURE: _____

161. PLACE OF SIGNATURE: _____

162. SIGNATURE OF DEPUTY CONSTABLE: _____

163. DATE OF SIGNATURE: _____

164. PLACE OF SIGNATURE: _____

165. SIGNATURE OF JURY: _____

166. DATE OF SIGNATURE: _____

167. PLACE OF SIGNATURE: _____

168. SIGNATURE OF JUDGE: _____

169. DATE OF SIGNATURE: _____

170. PLACE OF SIGNATURE: _____

171. SIGNATURE OF CLERK: _____

172. DATE OF SIGNATURE: _____

173. PLACE OF SIGNATURE: _____

174. SIGNATURE OF SHERIFF: _____

175. DATE OF SIGNATURE: _____

176. PLACE OF SIGNATURE: _____

177. SIGNATURE OF DEPUTY SHERIFF: _____

178. DATE OF SIGNATURE: _____

179. PLACE OF SIGNATURE: _____

180. SIGNATURE OF CONSTABLE: _____

181. DATE OF SIGNATURE: _____

182. PLACE OF SIGNATURE: _____

183. SIGNATURE OF DEPUTY CONSTABLE: _____

184. DATE OF SIGNATURE: _____

185. PLACE OF SIGNATURE: _____

186. SIGNATURE OF JURY: _____

187. DATE OF SIGNATURE: _____

188. PLACE OF SIGNATURE: _____

189. SIGNATURE OF JUDGE: _____

190. DATE OF SIGNATURE: _____

191. PLACE OF SIGNATURE: _____

192. SIGNATURE OF CLERK: _____

193. DATE OF SIGNATURE: _____

194. PLACE OF SIGNATURE: _____

195. SIGNATURE OF SHERIFF: _____

196. DATE OF SIGNATURE: _____

197. PLACE OF SIGNATURE: _____

198. SIGNATURE OF DEPUTY SHERIFF: _____

199. DATE OF SIGNATURE: _____

200. PLACE OF SIGNATURE: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01455

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in one-way within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 43 Pinewiff Beach</u>		d. STREET ADDRESS <u>Box 43 Rt 2</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>L</u> Last <u>LANE</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Printer's helper</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Printing shop</u>	
13. BIRTHPLACE (State or foreign country) <u>Scranton, Pa.</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>Frank Lane</u>		16. MOTHER'S MAIDEN NAME <u>Sarah Hiller</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		18. SOCIAL SECURITY NO. <u>1-1921 to 9-1921 577 14 0113</u>	
19. INFORMANT <u>Mrs. Alice I. Lane Wife Takoma Park, 12, Md.</u>		Address <u>905 Erie Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Old Pulmonary T B C</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>38 yrs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural causes</u>	
20c. TIME OF INJURY Month, Day, Year <u>Feb. 14 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Edgewater, A.A. Maryland</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>		DATE SIGNED <u>February 14, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 17, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>FEB 18 '59</u>	
ADDRESS <u>Annapolis, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 78
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1907

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO COUNTY

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DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO STATE

1422 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Baltimore 26 (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AA General Hospital		d. STREET ADDRESS 460 Carvel Beach Road	
3. NAME OF DECEASED (Type or print) First David Middle Harold Last Lehtma		4. DATE OF DEATH Month Feb. Day 5 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1958
9. AGE (In years last birthday) yrs. 9		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harold Lehtma		14. MOTHER'S MAIDEN NAME Carol Owen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. *****	
17. INFORMANT Mrs Harold Lehtma, Same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration, Circulatory collapse 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Profuse diarrhea, gastroenteritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 3 hours 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4 , 19 59 , to 2-5 , 19 59 , that I last saw the deceased alive on 2-5 , 19 59 , and that death occurred at 9 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Otto Vogel MD		DATE SIGNED 403 N. RICHIE H. 2-7-59	
PHYSICIAN'S NAME (Type) OTTO VOFEL, MD		GLEN BURNIE, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/7/59	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, M.		24a. REC'D BY REGISTRAR FEB 9 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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100

CERTIFICATE OF DEATH

01457

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freetown Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>		d. STREET ADDRESS <u>Box 326 Rt 1-</u>	
3. NAME OF DECEASED (Type or print) <u>Arthur Macey</u>		4. DATE OF DEATH <u>2-16-1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-1910</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Bernice Macey</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage -</u> DUE TO <u>Cerebral Vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Sclerosis Cerebrovascular</u> DUE TO (c) <u>Hypertensive Sclerosis Cerebrovascular</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19__		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-6-59</u> , 19 <u>59</u> , to <u>2-16-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-15-59</u> , 19 <u>59</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Gruber</u> M.D.		ADDRESS (Street, city or town, state) <u>P.O. Box 97 Odenton Md -</u>	
PHYSICIAN'S NAME (Type) <u>John G. Gruber</u>		DATE SIGNED <u>Feb 20 '59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/20/59</u>	<u>Mt Calvary</u>	<u>Q & Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaiah Brown for Morgan</u>		24a. REC'D BY REGISTRAR <u>Feb 20 '59</u>	
ADDRESS <u>108 W</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: MARY ANN]		SEX [Handwritten: F]		AGE [Handwritten: 48]	
DATE OF DEATH [Handwritten: 10/15/1918]		PLACE OF DEATH [Handwritten: HOME]		COUNTY [Handwritten: BALTIMORE]	
CAUSE OF DEATH [Handwritten: PNEUMONIA]		MANNER OF DEATH [Handwritten: NATURAL]		MEDICAL ATTENDANT [Handwritten: DR. J. H. [illegible]]	
PLACE OF BIRTH [Handwritten: BALTIMORE, MD]		DATE OF BIRTH [Handwritten: 10/15/1870]		PLACE OF BIRTH [Handwritten: BALTIMORE, MD]	
OCCUPATION [Handwritten: HOUSEWIFE]		MARITAL STATUS [Handwritten: MARRIED]		NAME OF SPOUSE [Handwritten: JOHN [illegible]]	
EDUCATION [Handwritten: HIGH SCHOOL]		RELIGION [Handwritten: METHODIST]		COLOR [Handwritten: WHITE]	
PREVIOUS ILLNESS [Handwritten: NONE]		TIME OF DEATH [Handwritten: 10:00 AM]		SIGNATURE OF DECEASED [Handwritten: MARY ANN]	
SIGNATURE OF MEDICAL ATTENDANT [Handwritten: DR. J. H. [illegible]]		SIGNATURE OF REGISTRAR [Handwritten: J. H. [illegible]]		SIGNATURE OF WITNESS [Handwritten: J. H. [illegible]]	

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE THAN THAT FOR WHICH IT WAS ISSUED.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01458

1469

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 23 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seaford	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS RFD 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elmer Middle Roland Last Matthews		4. DATE OF DEATH Month 2 Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1893
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown Farm	
11. BIRTHPLACE (State or foreign country) Unknown Dorches ter Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown William Thompson		14. MOTHER'S MAIDEN NAME Unknown Clara Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown No		16. SOCIAL SECURITY NO. 219-36-5139	
17. INFORMANT Unknown Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO (c) Arteriosclerotic Cardiovascular and Renal Disease with Hypertension		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. ----- 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that I attended the deceased from 1/9 , 1959, to 2/2 , 1959, that I last saw the deceased alive on 2/2 , 1959, and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 2/2/59 ACTUAL SIGNATURE Lionel McHenry Mapp, M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D. Crownsville State Hospital, Md. 2/2/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-7-59	22c. NAME OF CEMETERY OR CREMATORY Thompson town Cemetery	22d. LOCATION (City, town, or county) (State) Seaford Md.
23. FUNERAL DIRECTOR'S SIGNATURE J J Thompson, Son Federalburg Md.		24a. REC'D BY REGISTRAR DATE FEB 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01460

1423

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Ala</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Ala</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ala General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>I</i> Last <i>Owens</i>		4. DATE OF DEATH Month <i>2</i> Day <i>10</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 3-1886</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fireman Ret</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>City Fireman</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel Owens</i>		14. MOTHER'S MAIDEN NAME <i>Clara Basil</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Ruby E. Owens</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>181.7</i> <i>Memia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Causes of Death</i> DUE TO (c) <i>10mo</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1mo</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/7/58</i> , 19____, to <i>2/10/59</i> , 19____, that I last saw the deceased alive on <i>2/10/59</i> , 19____, and that death occurred at <i>2 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edwin Davis Jr., M.D.</i>		ADDRESS (Street, city or town, state) <i>98 Cathedral St Annapolis Md</i> DATE SIGNED <i>2/11/59</i>	
PHYSICIAN'S NAME (Type) <i>Edwin Davis Jr., M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-13-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Annes Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Scyla Sons</i> ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 13 '59</i>	
		24b. REGISTRAR'S SIGNATURE	

4 5 6 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01461

Reg. Dist. No.

1424

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leslie</u> Middle <u>Grace</u> Last <u>Page</u>		4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 6, 1959</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>18</u> Mins. <u>35</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Kenneth William Page</u>		14. MOTHER'S MAIDEN NAME <u>Frances Ruth Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mother</u>		Address <u>Rt. 2, Box 597B, Arnold, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ELYSIPICLAS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BACILLOCAL SEPTICEMIA</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>2 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 Feb</u> 19 <u>59</u> , to <u>8 Feb</u> 19 <u>59</u> , that I last saw the deceased alive on <u>8 Feb 59</u> , 19 <u>—</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 CATACEDON ST ANNAPOLIS, MD</u> DATE SIGNED <u>10 Feb 59</u>			
ACTUAL SIGNATURE <u>J. E. Walker</u> M.D.		PHYSICIAN'S NAME (Type) <u>J. E. Walker M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-10-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Taylor Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>FILED 1 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

1425

CERTIFICATE OF DEATH

Reg. Dist. No.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hospital</u>		d. STREET ADDRESS <u>54 St. Washington</u>	
3. NAME OF DECEASED (Type or print) First <u>Fannie B.</u> Middle <u>Queen</u> Last <u>Queen</u>		4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-5-1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Bryan</u>		14. MOTHER'S MARRIED NAME <u>Nellie Matthews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <u>no</u>)		16. SOCIAL SECURITY NO. <u>110-CLAY ST ANNAPOLIS, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1958</u> to <u>2-10-59</u> , that I lost the deceased alive on <u>2-10-59</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. R. Richardson</u>		ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, MD.</u> DATE SIGNED <u>2/11/59</u>	
PHYSICIAN'S NAME (Type) <u>William Seese, Jr. Annap. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-15-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Seese, Jr. Annap. Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>FEB 13 '59</u>			

James Buchanan

James Buchanan

James Buchanan

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James Buchanan

James Buchanan

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01464

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. General Hospital</u>				d. STREET ADDRESS <u>17 Cathedral St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>J.</u> Middle <u>Quigley</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>28</u> Year <u>1959</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>9-19-1896</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. Printer</u>		11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL Quigley</u>				14. MOTHER'S MAIDEN NAME <u>ANNA PURCELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>LESLIE A. Quigley #2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4 Cardiac disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. [unclear] & sons</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. [unclear]</u>			

STATE OF MARYLAND
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COUNTY OF _____ CITY OF _____	
DECEASED'S NAME _____ SEX _____ AGE _____ OCCUPATION _____	
PLACE OF DEATH _____ TIME OF DEATH _____ CAUSE OF DEATH _____	
MANNER OF DEATH _____ SIGNATURE OF EXAMINER _____ DATE _____	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1427

CERTIFICATE OF DEATH

01465

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>a a</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>annapolis</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>AA General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>BENJAMIN Redmiles</i>				4. DATE OF DEATH Month Day Year <i>Feb 3 1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/22/78</i>	
9. AGE (In years last birthday) yrs. <i>81</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Patuxent MD</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <i>Lemuel Redmiles</i>			
14. MOTHER'S MAIDEN NAME <i>Mary Ann Shoemaker</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>			
16. SOCIAL SECURITY NO. <i>57903-4218</i>				17. INFORMANT Address <i>ELIZABETH MORRIS Churchton MD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Blood transfusion for</i> (c) <i>Multiple gastric ulcer & hemorrhage</i> 2 Iwh-				INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of body of pancreas & metastases</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>2-2-1959</i> to <i>2-3-1959</i> that I last saw the deceased alive on <i>2-3-1959</i> , and that death occurred at <i>9:10 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Frank M Shipley</i> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <i>121 Cathedral St 2-59</i>			
PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>				<i>annapolis MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/5/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>WOODSIDE</i>		22d. LOCATION (City, town, or county) (State) <i>WOODSIDE REEL</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Harold Hardaway Salisbury Rd</i>				24a. REC'D BY REGISTRAR DATE <i>FEB 18 59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

[illegible]

FOR STATE
HEALTH DEPT.

Items 18-21 Film 239 3-16-59 ams

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1470

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				Cumberland 01X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hawkins Point, Chesapeake Bay			d. STREET ADDRESS R.F.D. 2, Box 341		
3. NAME OF DECEASED (Type or print) First JOHN Middle STONER Last REXRODE			4. DATE OF DEATH Month February Day 23 Year 19 59		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-15-1928		9. AGE (In years last birthday) 30 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane hooker		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Labon C. Rexrode			14. MOTHER'S MAIDEN NAME Fannie ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. 11 216-22-5080		17. INFORMANT Mrs. Doris W. Rexrode, Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning (body found buried in sand on river bank) 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found covered by sand on river bank on 2/23/59 Disappeared from home 12/12/58			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Found on river bank		20f. (City or town) Anne Arundel	(County) (State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Feb. 24, 1959	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-26-1959	22c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		22d. LOCATION (City, town, or county) (State) Finksburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE FEB 26 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hanes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1918

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH

AGE OF DECEASED
SEX OF DECEASED
RACE OF DECEASED

EDUCATION OF DECEASED
OCCUPATION OF DECEASED
MARRIAGE OF DECEASED

PREVIOUS ILLNESS
CAUSE OF DEATH
MANNER OF DEATH

TIME OF DEATH
PLACE OF DEATH
TEMPERATURE OF DEATH

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CERTIFICATE OF DEATH

01467

Reg. Dist. No.

1471

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lake Shore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Lake Shore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lake Shore Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle B. Last Rey				4. DATE OF DEATH Month February Day 2 Year 1959			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-7-88	
9. AGE (In years, last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min.		IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coast Guard				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI				16. SOCIAL SECURITY NO. 115-24-4152			
17. INFORMANT Family				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) generalized hypertrophic cardiomyopathy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute viral infection - 2 days duration							INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 years 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 15, 1950 , to February 2, 1959 , that I last saw the deceased alive on February 1, 1959 , and that death occurred at 2:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R.M. McLaughlin				ADDRESS (Street, city or town, state) RD 8 Box 442 Pasadena, Md.			
PHYSICIAN'S NAME (Type) R.M. McLaughlin				DATE SIGNED Feb. 2, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		2-5-59		MT. OLIVET Cem		Baltimore, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Mc Golly Funeral Home 130 E. Fort Ave.				24a. REC'D BY REGISTRAR FEB 3 '59		24b. REGISTRAR'S SIGNATURE Charles E. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>A. A. County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> COUNTY <i>A. A. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN Jb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ad. General Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Vincent Eric Roberts</i>		4. DATE OF DEATH <i>2-21-1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-1-1958</i>
9. AGE (In years last birthday) <i>4</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Richard Roberts Jr.</i>		14. MOTHER'S MAIDEN NAME <i>Arline Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Arline Williams</i>		Address <i>91 East St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Status epilepticus</i> <i>571.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>acute electrolyte disturbance</i> DUE TO (c) <i>Hyperpyrexia and sudden diabetes</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> <i>2 hrs.</i> <i>18 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>21 Feb</i> , 19 <i>59</i> , to <i>21 Feb</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>21 Feb</i> , 19 <i>59</i> , and that death occurred at <i>7:00 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James I. Hudson, Jr.</i>		ADDRESS (Street, city or town, state) <i>River Club Estates</i> DATE SIGNED <i>23 Feb 59</i>	
PHYSICIAN'S NAME (Type) <i>JAMES I. HUDSON, JR.</i>		<i>Edgewater Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>2-24-1959</i>	<i>Brewer Hall</i>	<i>Annapolis Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Keese #108 Wash St. Annapolis Md.</i>		24a. REC'D BY REGISTRAR <i>FEB 23 1959</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kane</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1472

CERTIFICATE OF DEATH

Reg. Dist. No.

01469

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>a.a.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>48 yrs.</u> x <u>Pasadena</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>P.O. Box 1 Mountain Road</u>		d. STREET ADDRESS <u>Mountain Road</u>	
3. NAME OF DECEASED (Type or print) <u>MYRTLE - MARIE - SCHRAMM</u>		4. DATE OF DEATH <u>Feb</u> Month <u>22</u> Day <u>1959</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Edgar Beale</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Deventerger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>William M. Schramm</u>		Address <u>Mountain Road 9900</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>156.1</u> IMMEDIATE CAUSE (a) <u>Carcinoma of the Liver.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>about 6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> 19 <u>—</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>58</u> , to <u>Feb 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 22</u> , 19 <u>59</u> , and that death occurred at <u>5 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James S. Bellingslee</u>		ADDRESS (Street, city or town, state) <u>108 Center St. Glenburn Md</u>	
PHYSICIAN'S NAME (Type) <u>James S. Bellingslee</u>		DATE SIGNED <u>Feb 23 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 25-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore City Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Tengel</u>		ADDRESS <u>5311 Edmondson Ave</u>	
24a. REC'D BY REGISTRAR <u>FEB 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

W. A. SYLVESTER, STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01470

1473

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 1 yr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 112 Jerome Parkway				d. STREET ADDRESS 112 Jerome Parkway			
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle L. Last SEHLHORST				4. DATE OF DEATH Month February Day 2 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 3 1903	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Clerk		Drug		MD		USA	
13. FATHER'S NAME Frank Sehlhorst				14. MOTHER'S MAIDEN NAME Matilda Trossback			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 21609-2319		17. INFORMANT Fred Sehlhorst Address 112 Jerome Parkway			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Alcoholism. 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Paul F. Guerin				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 2/2/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 5-59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town or county) (State) Belair Rd Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Phinard A Frank				24a. REC'D BY REGISTRAR Feb 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knead	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Anna Arnold

John Arnold

1221 North Broadway

DEATH

Tuberculosis

Heart Disease

John Arnold

John Arnold

1221 North Broadway

DEATH

EXAMINER

John S. Smith

2/4/22

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

142D

CERTIFICATE OF DEATH

Reg. Dist. No.

01471

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNDT DANNAPOLIS 24 hrs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL</u>				d. STREET ADDRESS <u>R. R. #1, Box 254</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>TERRY Lee SHOPE</u>				4. DATE OF DEATH Month Day Year <u>2 28 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-48</u>	9. AGE (In years last birthday) <u>10</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>EARL M. SHOPE</u>				14. MOTHER'S MAIDEN NAME <u>Martha L. Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>FATHER</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Febr. 27, 1959</u> , to <u>Febr. 28, 1959</u> , that I last saw the deceased alive on <u>Febr. 28, 1959</u> , and that death occurred at <u>8:20 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clayton Norton</u>				ADDRESS (Street, city or town, state) <u>Med. Arts Bldg., Severna Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Clayton Norton</u>				DATE SIGNED <u>2-28-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>March 4, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton Home Home Helen Bernin</u>				24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH _____		SEX _____	
DATE OF BIRTH _____		AGE _____	
OCCUPATION _____		CAUSE OF DEATH _____	
PLACE OF DEATH _____		DATE OF DEATH _____	
TIME OF DEATH _____		SIGNATURE OF DECEASED _____	
SIGNATURE OF WITNESS _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF CLERK _____		SIGNATURE OF JUDGE _____	
SIGNATURE OF SHERIFF _____		SIGNATURE OF CORONER _____	
SIGNATURE OF MINISTERS _____		SIGNATURE OF CHURCH _____	
SIGNATURE OF BURIAL _____		SIGNATURE OF CEMETERY _____	
SIGNATURE OF FUNERAL HOME _____		SIGNATURE OF STATE DEPARTMENT OF HEALTH _____	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his or her illness or who has attended the deceased at the time of death. It is to be signed by the physician or other qualified person who has attended the deceased during his or her illness or who has attended the deceased at the time of death. It is to be signed by the physician or other qualified person who has attended the deceased during his or her illness or who has attended the deceased at the time of death.

Item 20 Film 239 3-6-59 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

01472

1474

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEO. G. MEADE				c. LENGTH OF STAY IN 1b X FORT GEO. G. MEADE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. ARMY HOSPITAL				d. STREET ADDRESS Co A USA Support Element			
3. NAME OF DECEASED (Type or print) First Richard Middle - Last Silverman				4. DATE OF DEATH Month February Day 25 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 May 1937		9. AGE (In years last birthday) 21 yrs.	10. IF UNDER 1 YEAR Months 21 Days 14 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U. S. ARMY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph Silverman				14. MOTHER'S MAIDEN NAME Mary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 26Nov56 to date 357-28-56144		17. INFORMANT Personnel Records Address Ft George G. Meade, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carbon Monoxide Inhalation DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH DOA	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject apparently committed suicide by sitting in car with engine running and doors closed					
20c. TIME OF INJURY Hour 0055 o. m. XXXX Month Feb Day 25 Year 1959		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Near Bldg T-48		20f. (City or town) (County) (State) FORT GEO. G. MEADE AA MD	
21. I certify that I attended the deceased from 25 Feb , 19 59 , to 25 Feb , 19 59 , that I last saw the deceased alive on 19 , and that death occurred at 0055 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAH, Ft G. G. Meade, Md DATE SIGNED 25 Feb 59							
ACTUAL SIGNATURE <i>Myron J. Myers</i>		M.D. USAH, Ft G. G. Meade, Md					
PHYSICIAN'S NAME (Type) MYRON J MYERS, MD		USAH Ft George G. Meade, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 2-26-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery		22d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE MAR 2 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

2

50

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01475

1475

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 3mo. 3yrs. 14days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle A. Last Small				4. DATE OF DEATH Month 2 Day 23 Year 1959			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/28/71	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 08 Days x		IF UNDER 24 HRS. Hours 2 Min. 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Small				14. MOTHER'S MAIDEN NAME Henrietta Grey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-18-8402		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO Advanced Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5-10 years (c)							INTERVAL BETWEEN ONSET AND DEATH 72 Hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) ----- (County) ----- (State) -----							
21. I certify that I attended the deceased from 11/9 , 19 55 , to 2/23 , 19 59 , that I last saw the deceased alive on 2/23 , 19 59 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leonardo Garcia-Bunuel M.D.				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 2/23/59			
PHYSICIAN'S NAME (Type) Leonardo Garcia-Bunuel				ADDRESS Crownsville State Hospital, Md. DATE SIGNED 2/23/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-27-59		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's CEM.		22d. LOCATION (City, town, or county) Pomphrey, Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Milton E. Blichman ADDRESS 1129 N. Caroline St,				24a. REC'D BY REGISTRAR FEB 25 59 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1430

CERTIFICATE OF DEATH

01474

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Bryant Last Snead				4. DATE OF DEATH Month February Day 20 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 20, 1959	
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Annapolis, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Gilbert Floyd Snead				14. MOTHER'S MAIDEN NAME Arline Louise Erheart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none				17. INFORMANT Mother Address Riva, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mediastinal emphysema + bilateral pneumothorax 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spontaneous alveolar ruptures near perihilar vessels DUE TO (c) 2 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 21 Feb , 19 59 , to 21 Feb , 19 59 , that I last saw the deceased alive on 21 Feb , 19 59 , and that death occurred at 3:30 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James I. Hudson, Jr. M.D. River Club Estates ADDRESS (Street, city or town, state) Edgewater, Md. DATE SIGNED 23 Feb 59							
PHYSICIAN'S NAME (Type) JAMES I. HUDSON, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-24-59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR FEB 25 '59 DATE		24b. REGISTRAR'S SIGNATURE Charles S. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1431

Item 8 Film 238 2-15-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 01475

1. PLACE OF DEATH a. COUNTY <u>Bare Run</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA-PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brundel General Hospital</u>		d. STREET ADDRESS <u>OLD County Road</u>	
3. NAME OF DECEASED (Type or print) <u>FRANCES E STEWART</u>		4. DATE OF DEATH <u>2</u> Month <u>5</u> Day <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>VA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>CHARLES PERKINS</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>JOSEPH S. STEWART</u> Address <u>SEVERNA PK</u>		Interval BETWEEN ONSET AND DEATH <u>4:00 AM</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EMBOLUS</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/4</u> , 19 <u>55</u> , to <u>2/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/5</u> , 19 <u>59</u> , and that death occurred at <u>4:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Reeler</u>		ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST</u> DATE SIGNED <u>2/5/59</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. REELER</u>		<u>ANNAPOLIS MD</u>	
22a. BURIAL, CREMATION, (Specify)		22b. DATE THEREOF <u>2/8-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ELTIS CHURCH</u>		22d. LOCATION (City, town, or county) (State) <u>PERKINSVILLE VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>FRANK W. SEITZ</u> ADDRESS <u>814 N. 36th St</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	
DATE <u>FEB 9 '59</u>			

Baltimore 11 Md

1432

CERTIFICATE OF DEATH

Reg. Dist. No.

01476

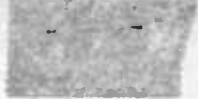
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>1 day</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena, RFD</u> d. STREET ADDRESS <u>Rt. 9 Box 359,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>EARL R. TAYLOR</u>			4. DATE OF DEATH Month Day Year <u>February 20, 19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1898</u>	9. AGE (In years last birthday) yrs. <u>60</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Riverton, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Edward R. Taylor</u>		
14. MOTHER'S MAIDEN NAME <u>Florence E. Ellinsworth</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		
16. SOCIAL SECURITY NO. <u>Unknown</u>			INFORMANT Address <u>Mr. James M. Taylor, Pasadena, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe pulmonary emphysema + fibrosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>2/18</u> , 19 <u>59</u> , to <u>2/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/20</u> , 19 <u>59</u> , and that death occurred at <u>2:40</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. Hedemen</u>		ADDRESS (Street, city or town, state) <u>121 Cathedral</u>		DATE SIGNED <u>2/20/59</u>	
PHYSICIAN'S NAME (Type) <u>John P. Hedemen</u>		<u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Burnie Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Richard K. Singleton</u>			
ADDRESS <u>Glen Burnie, Md.</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10/10/2010

10/10/2010



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01477

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>ANNA ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>301 Highway</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md 301-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>420 N. Green St.</u>	
3. NAME OF DECEASED (Type or print) <u>William W. Teat</u>		4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/107</u>
9. AGE (in years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC Teat</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Munnery</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-03-0631</u>	
17. INFORMANT <u>Margaret White, Baltimore, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple contusions, crushed skull</u> <u>825x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>auto accident</u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>1:46</u> a. m. <u>2-12-1959</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road (highway)</u>	20f. (City or town) (County) (State) <u>Bt 301 + Swamp Run Rd. A.A.G. Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Emily H. Wilson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u> </u>		DATE SIGNED <u>2-12-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Goldtown Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Carmichael, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James R. Roswell, Boston, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		24c. REGISTRAR'S SIGNATURE	

Reg. Dist. No.

MEDICAL CERTIFICATION

1. **MAIN BOARD**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1478

CERTIFICATE OF DEATH

01479

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wild Rose Shore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>* Annapolis R. F. D.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Wild Rose Shore</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Toohey</u> Last <u>Toohey</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28th 1890</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Courtney</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs John J. Lausch</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia (lobar)</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Upper respiratory infection</u> DUE TO (c) <u>gen. arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u>19</u> Year <u> </u> Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 21st 1958</u> to <u>Feb 18th 1959</u> , that I last saw the deceased alive on <u>Feb 15th 1959</u> , and that death occurred at <u>440P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith A. Geller</u>		ADDRESS (Street, city or town, state) <u>45 Franklin St. Annapolis, Md. 21403</u>	
PHYSICIAN'S NAME (Type) <u>Edith A. Geller</u>		DATE SIGNED <u>Feb 24 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	22d. LOCATION (City, town, or county) (State) <u>Brooklyn N. Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>Annapolis Md</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>		DATE <u>FEB 24 59</u>	

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		PLACE OF DEATH HOME	
COUNTY BALTIMORE		COUNTY BALTIMORE	
CITY BALTIMORE		CITY BALTIMORE	
STREET 1234 5th Ave.		STREET 1234 5th Ave.	
APARTMENT 101		APARTMENT 101	
DECEASED JOHN DOE		DECEASED JOHN DOE	
SEX MALE		SEX MALE	
AGE 45		AGE 45	
DATE OF BIRTH 10-15-1900		DATE OF BIRTH 10-15-1900	
PLACE OF BIRTH BALTIMORE, MD.		PLACE OF BIRTH BALTIMORE, MD.	
OCCUPATION CLERK		OCCUPATION CLERK	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF PHYSICIAN J. H. SMITH	
SIGNATURE OF DEATH REGISTRAR A. B. JONES		SIGNATURE OF DEATH REGISTRAR A. B. JONES	
DATE OF DEATH 11-1-1945		DATE OF DEATH 11-1-1945	
TIME OF DEATH 10:00 AM		TIME OF DEATH 10:00 AM	
PLACE OF INTERMENT GREENWICH CEMETERY		PLACE OF INTERMENT GREENWICH CEMETERY	
NAME OF INTERMENT JOHN DOE		NAME OF INTERMENT JOHN DOE	
DATE OF INTERMENT 11-1-1945		DATE OF INTERMENT 11-1-1945	
TIME OF INTERMENT 11:00 AM		TIME OF INTERMENT 11:00 AM	

1479
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 35yr 8mo 24da d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3 V 0 1 - 4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Violet		4. DATE OF DEATH Month 2 Day 9 Year 19 59	
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1902?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) yrs. 56?
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Dilatation of Stomach 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Ampulla of Vater DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- p. m. ----- 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/15 to 2/9 , 19 59 , that I last saw the deceased alive on 2/9 , 19 59 , and that death occurred at 1:50 A.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>	DATE SIGNED 2/9/59
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.	ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.
	DATE SIGNED 2/9/59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb 12th 1959	22c. NAME OF CEMETERY OR CREMATORY Int. Calvary	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph L. Russ		24a. REC'D BY REGISTRAR FEB 11 1959	
ADDRESS 1222 W. North Ave		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01481

Reg. Dist. No.

1480

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>ARCO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ARCO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savanna Park</u>	c. LENGTH OF STAY IN 1b <u>25 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLEIGH Hgts.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Truck House Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES MELVIN WALBECK</u>		4. DATE OF DEATH Month Day Year <u>2 12 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 30 - 1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Poultry</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adam G Walbeck</u>		14. MOTHER'S MAIDEN NAME <u>Cora Delevett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES World War I</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Judith J. Walbeck</u>		Address <u>Savanna Park Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (a), stating the underlying cause last. DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb 16 - 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Deer Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Chestnut Hill Harford</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Krutz</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kenna</u>	
ADDRESS <u>Jane Walbeck Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	
DATE <u>FEB 19 '59</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE [Faint text, possibly "45"]		RACE <input checked="" type="checkbox"/> WHITE <input type="checkbox"/> COLORED	
DATE OF DEATH [Faint text, possibly "JAN 15 1921"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
PLACE OF DEATH [Faint text, possibly "HOME"]		CITY [Faint text, possibly "BALTIMORE"]	
STREET [Faint text, possibly "1234 MAIN ST"]		COUNTY [Faint text, possibly "BALTIMORE"]	
STATE [Faint text, possibly "MD"]		ZIP CODE [Faint text, possibly "21201"]	
OCCUPATION [Faint text, possibly "Carpenter"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
MANNER OF DEATH <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE		MEDICAL HISTORY [Faint text, possibly "No previous illness"]	
SIGNATURE OF EXAMINER [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	
DATE OF EXAMINATION [Faint text, possibly "JAN 15 1921"]		TIME OF EXAMINATION [Faint text, possibly "10:00 AM"]	

NOT FOR CIRCULATION

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF BALTIMORE, MD. FOR RECORDING IN THE DEATH RECORDS.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1481 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01482

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA.CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA.CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jones Station</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Jones Station</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>B</u> Last <u>White</u>		4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AA.CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>AA.CO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AA.CO.</u>	
13. FATHER'S NAME <u>Henson Brown</u>		14. MOTHER'S MAIDEN NAME <u>Charles Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Theodore White Jones Station</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c) <u>—</u> DUE TO underlying cause lost. (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-1-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CARPENTERS HILL</u>		22d. LOCATION (City, town, or county) (State) <u>Jones - AA.CO. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u>		24a. REC'D BY REGISTRAR <u>ANNA, Md</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>MAR 2 '59</u>	

IN A

REGISTERED

PLACE HERE

DATE

TIME

LOCATION

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF REINTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF REINTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

PLACE HERE

DATE

TIME

LOCATION

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

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DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF EXHUMATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01483

1482

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 18 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 179 W. All Saints Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary		First Mary		Last Williams		4. DATE OF DEATH Month 2 Day 10 Year 1959	
5. SEX female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1892	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 10 Days 11 Hours 2		IF UNDER 24 HRS. Hours 19 Min. 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/22/1959 to 2/10/1959 , that I last saw the deceased alive on 2/10/1959 and that death occurred at 4:42 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 2/10/59 ACTUAL SIGNATURE Lionel McHenry Mapp, M.D. M.D. Crownsville State Hospital, Md. 2/10/59 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-14-59		22c. NAME OF CEMETERY OR CREMATORY Hope Hill		22d. LOCATION (City, town, or county) (State) Frederick-Co-Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks ADDRESS Frederick, Md.				24a. REC'D BY REGISTRAR DATE FEB 17 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

REG. NO. 11

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

1. NAME OF DECEASED: JOHN J. HENRY

2. SEX: MALE

3. AGE: 45

4. DATE OF DEATH: SEP 10 1922

5. TIME OF DEATH: 10:30 AM

6. PLACE OF DEATH: HOME

7. CAUSE OF DEATH: HEART DISEASE

8. DISEASE OR INJURY: ANGINA PECTORIS

9. PERIOD OF ILLNESS: 2 WEEKS

10. PREVIOUS ILLNESS: NO

11. OCCASION OF DEATH: AT HOME

12. SIGNATURE OF PHYSICIAN: JOHN J. HENRY

13. SIGNATURE OF REGISTRAR: JOHN J. HENRY

14. SIGNATURE OF CLERK: JOHN J. HENRY

15. SIGNATURE OF DECEASED: JOHN J. HENRY

16. SIGNATURE OF WITNESSES: JOHN J. HENRY

17. SIGNATURE OF DECEASED: JOHN J. HENRY

18. SIGNATURE OF DECEASED: JOHN J. HENRY

19. SIGNATURE OF DECEASED: JOHN J. HENRY

20. SIGNATURE OF DECEASED: JOHN J. HENRY

21. SIGNATURE OF DECEASED: JOHN J. HENRY

22. SIGNATURE OF DECEASED: JOHN J. HENRY

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01484

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn 25</u> c. LENGTH OF STAY IN 1b <u>1 1/2</u> year		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William E. Wolfe</u> First Middle Last		4. DATE OF DEATH <u>February 7th.</u> 19 <u>59</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-1878</u> 9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Telegraph Operator, P.R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Johnstown, Penn.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph E. Wolfe</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Myers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Myra Reilly (Niece)</u>		Address <u>216 Riverside Rd. Brooklyn</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-8-59 Removal</u>		22b. DATE THEREOF <u>2/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HOLY SEPULCHRE</u>		22d. LOCATION (City, town, or county) (State) <u>WYNDMOOR, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Fickner & Sons, North & Pa. Aves Balto., Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

PLACE TO PRINT
A-200

MARRIAGE

STATUS OF DECEASED: SINGLE, MARRIED, DIVORCED, WIDOWED, SEPARATED, RE-MARRIED, OTHER

PLACE TO PRINT
A-200

CAUSE OF DEATH
IMMEDIATE
INTERMEDIATE
UNDERLYING

PLACE TO PRINT
A-200

of

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01485

1433

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL CO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
c. LENGTH OF STAY IN 1b <u>LIFE</u>				d. STREET ADDRESS <u>4 CUMBERLAND COURT</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET TAYLOR RANDALL WORTHINGTON</u>				4. DATE OF DEATH <u>FEBRUARY 17 19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 14, 1861</u>	9. AGE (In years last birthday) <u>98 yrs.</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>BURTON RANDALL</u>			
14. MOTHER'S MAIDEN NAME <u>VIRGINIA TAYLOR</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>VIRGINIA R. WORTHINGTON #2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac respiratory failure</u> 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility & dehydration</u> DUE TO (c) <u>Dehydration</u>							INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> <u>2 yrs</u> <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Violently uncooperative, IV fluids impossible</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on attempting to rise from her chair</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10:30</u> Feb. 4 19 <u>59</u> p. m. <u>Feb. 4</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Annapolis</u> (County) <u>Anne</u> (State) <u>MD</u>				21. I certify that I attended the deceased from <u>Feb 4</u> , 19 <u>59</u> , to <u>Feb 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 16</u> , 19 <u>59</u> , and that death occurred at <u>12:54</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold R. Bohman</u> M.D.				DATE SIGNED <u>Feb 18, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Harold R. Bohman MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. ANNES</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor and Sons</u> ADDRESS <u>ANNAPOLIS, MD.</u>				24a. REC'D BY REGISTRAR <u>FEB 24 59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
JAMES EARL RAY		M		35		W		12/1/28		MEMPHIS, TENN.		4/4/68		MEMPHIS, TENN.	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PRESENT ILLNESS		14. TREATMENT		15. POST-MORTEM		16. SIGNATURE OF PHYSICIAN	
ATTORNEY		HEART DISEASE		NATURAL		HYPERTENSION		CORONARY THROMBOSIS		MEDICATION		AUTOPSY		J. H. [Signature]	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF CLERK		20. SIGNATURE OF PHYSICIAN		21. SIGNATURE OF DEATH CERTIFICATE		22. SIGNATURE OF DEATH CERTIFICATE		23. SIGNATURE OF DEATH CERTIFICATE		24. SIGNATURE OF DEATH CERTIFICATE	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18